INFANT BOTULISM INVESTIGATION FORM (page 1 of 4)

PERSONAL DATA

Individual reporting (initial call) Name:_____ Phone number:_____ Name of patient:_____ Birth date:_____ Sex:_____

Ethnicity: Race: _____ (W=white, B=Black, I=Am Indian, A=Asian, H=Hispanic, O=Other)

Patient address:_____ Patient phone number:_____

Hospital:_____ Hospital phone number:_____

Physician:_____ Physician phone number:_____

Physician address:_____ Mother's Occupation: _____ Father's Occupation: _____

What was infant's birth weight: _____ (lb) _____ (oz) _____ (gms) Was infant premature: Yes 9 No 9 unknown

If yes, gestational age: _____ weeks Type of delivery: Vaginal: ____ C-Section: _____

DIETARY HISTORY (BEFORE ONSET OF PRESENT ILLNESS)

PRESENT ILLNESS-INFANT BOTULISM (Defined as onset of constipation or if no constipation when mother says child became ill)

Before onset of present illness:

Was infant ever breast fed: Yes 9 No 9 If yes, for how many weeks:

Was infant ever formula fed: Yes 9 No 9 Formula with iron: Yes 9 No 9

Was infant primarily (more than 50%):

Breast fed: Yes 9 No 9 Formula fed: Yes 9 No 9 Both approximately equally Yes 9 No 9

Did infant ever eat or taste (Before onset of illness):

Food/Liquid	Never	Once or a Few Times	Many Times	Daily or Most Days	Principal Type or Brand
formula					
cow's milk					
fruit juices					
cereal					
bread					
syrup/water					
honey/water					
sugar/water					
tea/water					
fruits, cooked					
fruits, raw					
vegetables, cooked					
vegetables, raw					
home-canned foods					
baby foods, jars					
other					

Did the infant use a pacifier: often 9 sometime 9 rarely 9 no 9

If Yes, was it ever dipped in : syrup 9 honey 9 other 9 nothing 9

PHYSICAL FINDINGS

SIGNS: (*are typical):	YES	NO	UNKNOWN
a) Loss of facial expression	9	9	9
b) Ptosis	9	9	9
c) Extraocular muscle palsies	9	9	9
d) Pupils:			
1) dilated	9	9	9
2) Pupils constricted	9	9	9
3) Sluggish pupil reactivity	9	9	9
e) Trouble swallowing	9	9	9
f) Constipation	9	9	9
g) Diarrhea	9	9	9
h) Altered cry	9	9	9
i) Weak sucking	9	9	9
j) Muscle weakness			
1) poor head control	9	9	9
2) upper extremities	9	9	9
3) lower extremities	9	9	9
4) "floppy"	9	9	9

SIGNS: (cont'd)	YES	NO	UNKNOWN
k) Knee deep tendon reflex	9	9	9
1) absent	9	9	9
2) depressed	9	9	9
l) Somnolent	9	9	9
m) Irritable	9	9	9
n) Fever	9	9	9
o) Dehydration	9	9	9
p) Respiratory difficulty	9	9	9
q) Respiratory arrest	9	9	9
r) Pneumonia	9	9	9
s) Other:_____			

DIAGNOSTIC TESTS

Laboratory results: a) spinal tap Yes 9 No 9
(*Normal in botulism, myasthenia gravis; protein may be elevated in Guillain-Barre*)

Date	RBC's (0)	WBC's (<10)	Protein (15-45 mg%)	Glucose (50-70 mg%)	Other

Tensilon test: (*Negative in botulism and Guillain-Barre, positive in myasthenia gravis. After administration of Tensilon (edrophonium chloride) the patient's eye signs (ptosis & extraocular abnormalities) markedly decrease*.)

Date	Positive	Negative	Equivocal	Not done

EMG results (electromyography): (*Botulism: action potential diminished after single supramaximal stimulus, facilitation with repetitive stimuli at 20-50/sec)* (*Myasthenia gravis: similar to botulism*) (*In Guillain-Barre: slowed nerve conduction, whereas there is normal conduction in botulism*)

Date	Nerve Stimulated	Stimulated Frequency	Not done	Amplitude (Circle One)	Facilitation
				increase / decrease	Yes 9 No 9
				increase / decrease	Yes 9 No 9

INFANT BOTULISM INVESTIGATION FORM (page 3 of 4)

CURRENT SYMPTOMS

Mother first noted infant was ill on _____ at _____ weeks of age.
(mo./day/yr.)

First symptom:_____

Second Symptom:_____

The initial visit to a physician was on _____ at _____ weeks of age.
(mo./day/yr.)

Infant was hospitalized on _____ at _____ weeks of age.
(mo./day/yr.)

Symptoms noted before patient hospitalized:	YES	NO	UNKNOWN
Constipation_____ (mo./day/yr.)	9	9	9
Poor feeding	9	9	9
Altered cry	9	9	9
Irritable	9	9	9
Poor head control	9	9	9
General weakness	9	9	9
Difficulty breathing	9	9	9
Fever	9	9	9
Other: _____			

If infant had constipation, how many bowel movements were occurring:

____ two or more per day ____ one per day

____ one every other day ____ two to three per week

____ one per week ____ less than one per week

____ other

PHYSICIAN/HOSPITAL DATA

_____ _____ _____
(Physician Name) (Physician Address) (Physician Phone)

_____ _____ _____
(Physician Name) (Physician Address) (Physician Phone)

_____ _____ _____ _____
(Hospital Name) (Medical Record #) (Date Admitted) (Date Discharged)

_____
(Hospital Address)

_____ _____ _____ _____
(Hospital Name) (Medical Record #) (Date Admitted) (Date Discharged)

_____
(Hospital Address)

TREATMENT

Respiratory assistance needed: Yes 9 No 9 Unknown 9 _____ (No. of days)

oxygen only Yes 9 No 9 tracheostomy Yes 9 No 9

intubation Yes 9 No 9 ventilator Yes 9 No 9

Infant feeding: feeding tube Yes 9 No 9 Unknown 9 _____ (No. of days)

Antibiotics given: Drug	Oral/Parenteral	Dose (gms/day)	Duration (days)	Date started (month/day)

Was antitoxin given: Yes 9 No 9 If yes, give route of admission: I.V. 9 I.M. 9 both 9 unknown 9

If yes, how many c.c. total (connaught adult 10cc/vial, connaught ped. 2 cc/vial): _____ total cc

Other specific therapeutic medication given: _____

Patient outcome: improving 9 recovered 9 death 9 If patient died: _____
(Date of Death)

ENVIRONMENTAL HISTORY

Was there any construction, excessive dust, or environmental change around home from birth of infant, until onset of present illness (infant botulism): Yes **9** No **9** Unknown **9**

If yes, describe:

_____

Was parent(s) involved in gardening or yard work from birth of infant until onset of present illness: Yes **9** No **9** Unknown **9**

If yes, describe:

_____

Did infant remain away from home for more than 1 week prior to onset of present illness? Yes **9** No **9** Unknown **9**

If yes, describe:

_____

SUBMITTER

Form reviewed and submitted by:

Name:_____ Title: _____

Agency: _____ Phone: _____

Date: _____

FORM SUBMISSION

Return copy of form to:

Texas Department of Health
Attn: Infectious Disease Epidemiology and Surveillance Division
1100 West 49th Street
Austin, TX 78756-3199